Hawaii Dept. of Health, Office of Health Care Assurance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 12G036 | A. BUILDING: _____ B. WING _____ | 10/20/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ARC OF MAUI - HALE KIHEI | 179 HALE KAI STREET KIHEI, HI 96753 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 9 000 | INITIAL COMMENTS<br><br>A licensure survey was conducted by the Office of Health Care Assurance from October 18, 2021 through October 20, 2021. There were five clients residing in this home, three clients were selected for the sample. The facility was found to be in compliance with requirements for Title 11, Chapter 99, Subchapter 1, Small Intermediate Care Facilities for Individuals with Intellectual Disabilities. | 9 000 | | |

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE